L. KEVIN METSGER, D.M.D.
progressive dental studio

520 Pellis Road
Suite 4000
Greensburg, PA 15601

phone (724) 837-5009
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Our goal is to provide our patients the most healthy, beautiful smiles they deserve.

Today's date: _____

ABOUT YOU

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Please check contact preference:

Home phone: ☐ _____ Work phone: ☐ _____

Cell phone: ☐ _____ Texts: ☐ E-mail: ☐ _____

Date of birth: _____ SSN: _____

Name of spouse: _____

Name(s) of children: _____

Name of your employer: _____

Who can we thank for referring you to our office? _____

EMERGENCY INFORMATION

Person to contact: _____ Relationship: _____

Home phone: _____ Cell phone: _____

INSURANCE INFORMATION

Insurance company name: _____ Group #: _____

ID/Social Security #: _____

Employer: _____

If spouse is your policy holder:

Spouse's date of birth: _____/_____/_____ Spouse's SS#: _____-_____-_____

Spouse's employer: _____

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges, to the extent permitted under applicable law. I authorize release of information relating to this claim. I also authorize payment of dental benefits, otherwise payable to me, to be paid directly to L. Kevin Metsger, D.M.D.. Initials: _____

APPOINTMENT CANCELLATION POLICY

When you schedule an appointment, we reserve that time and prepare in anticipation of serving you. If you should need to reschedule, **we kindly request that you contact us by phone with advance notice of 24 hours**. We understand that conflicts arise; however, failing your appointment or canceling without adequate notice more than once will result in a no-show fee. Initials: _____

MEDICAL HISTORY

Please list all current **medications/vitamins/herbal supplements**:

_____ purpose _____

_____ purpose _____

_____ purpose _____

_____ purpose _____

_____ purpose _____

_____ purpose _____

(For women) Are you currently pregnant? ☐ yes ☐ no If yes, how many months? _____

Are you currently taking birth control? ☐ yes ☐ no If yes, name: _____

Are you currently or have you ever taken any bisphosphonates (Fosomax, Zometa, Boniva, Actonel, Reclast, other)? ☐ yes ☐ no If yes, name: _____

Do you know your blood pressure? ☐ yes ☐ no If yes, what is it? _____

Please check if you are allergic to any of the following:

☐ Local anesthesia ☐ Sulfa drugs ☐ Codeine/other narcotics

☐ Penicillin/other antibiotics ☐ Aspirin ☐ Latex sensitivity

☐ Barbiturates, sedatives, sleeping pills ☐ Shellfish, iodine or red wine ☐ Other _____

Do you have, or have you ever had, any of the following?

Y	N		Y	N		Y	N		Y	N	
☐	☐	AIDS/HIV Positive	☐	☐	Drug Addiction	☐	☐	Hepatitis B or C	☐	☐	Rheumatism
☐	☐	Alzheimer's Disease	☐	☐	Easily Winded	☐	☐	Herpes	☐	☐	Scarlet Fever
☐	☐	Anaphylaxis	☐	☐	Emphysema	☐	☐	High Blood Pressure	☐	☐	Shingles
☐	☐	Arthritis/Gout	☐	☐	Epilepsy or Seizures	☐	☐	Hives or Rash	☐	☐	Sickle Cell Disease
☐	☐	Artificial Heart Valve	☐	☐	Excessive Bleeding	☐	☐	Hypoglycemia	☐	☐	Sinus Trouble
☐	☐	Asthma	☐	☐	Excessive Thirst	☐	☐	Irregular Heartbeat	☐	☐	Spina Bifida
☐	☐	Blood Disease	☐	☐	Frequent Cough	☐	☐	Leukemia	☐	☐	Stroke
☐	☐	Breathing Problem	☐	☐	Frequent Headaches	☐	☐	Liver Disease	☐	☐	Swelling of Limbs
☐	☐	Bruise Easily	☐	☐	Glaucoma	☐	☐	Lung Disease	☐	☐	Thyroid Disease
☐	☐	Cancer	☐	☐	Hay Fever	☐	☐	Mitral Valve Prolapse	☐	☐	Tonsillitis
☐	☐	Chemotherapy	☐	☐	Heart Attack/Failure	☐	☐	Parathyroid Disease	☐	☐	Tuberculosis
☐	☐	Chest Pains	☐	☐	Heart Murmur	☐	☐	Psychiatric Care	☐	☐	Tumors or Growths
☐	☐	Cold Sores/Fever Blisters	☐	☐	Heart Pace Maker	☐	☐	Radiation Treatment	☐	☐	Ulcers
☐	☐	Congenital Heart Disorder	☐	☐	Heart Trouble/Disease	☐	☐	Recent Weight Loss	☐	☐	Venereal Disease
☐	☐	Convulsions	☐	☐	Hemophilia	☐	☐	Renal Dialysis	☐	☐	Yellow Jaundice
☐	☐	Cortisone Medicine	☐	☐	Hepatitis A	☐	☐	Rheumatic Fever			
☐	☐	Diabetes	☐	☐	Artificial Joint	If yes, date placed: _____					

MEDICAL HISTORY (continued)

Have you ever had any serious illness not listed on the previous page? If yes, please explain: _____

_____

Due to any of the conditions listed on the previous page, has it been recommended by your physician that you need to ***premedicate with an antibiotic***? ☐ yes ☐ no

DENTAL HISTORY

Is there something you would like to change about your smile? ☐ yes ☐ no If yes, what? _____

_____

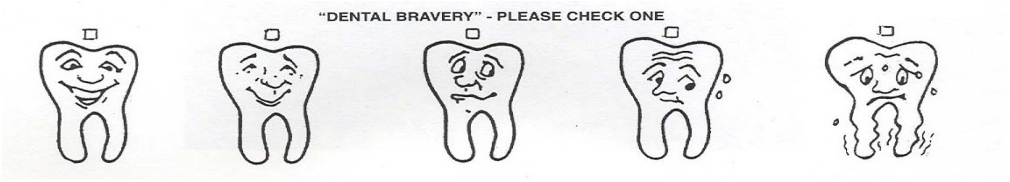
Date of your last hygiene visit? _____

What is the main reason for your visit today?

☐ Tooth Pain ☐ I need a check-up ☐ Cleaning ☐ Whitening

☐ Orthodontics ☐ Cosmetic Dentistry ☐ Sedation Dentistry

☐ Other: _____



When a healthcare worker is exposed to my blood or body fluids through a needle stick, cut or splash to the eye or mouth, I agree to have my blood drawn and tested for blood-borne diseases to include Hepatitis B and C Virus, and Human Immunodeficiency Virus (AIDS). _____Initial

The information I have given is true and accurate to the best of my knowledge:

_____ _____

Date Signature of person completing health history

I would like to learn more about:

☐ Orthodontics ☐ Whitening

☐ Implants ☐ Bridges

☐ Veneers ☐ Dentures

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